Insurance and Real Estate Committee
PUBLIC HEARING
Thursday, March 17, 2022

Connecticut Association of Health Plans
Testimony in Opposition to

S.B. No. 415 AAC STEP THERAPY, ADVERSE DETERMINATION AND UTILIZATION REVIEWS.

The Connecticut Association respectfully urges opposition to S.B. 415.

S.B. 415 is representative of several bills in one, that will:

- **Price health care coverage out of reach for millions of Connecticut residents; and,**
- **Undermine the critical clinical safeguards that protect consumers from unnecessary or unwarranted treatment**. More treatment is not necessarily better treatment.

The estimated fiscal Impact of the legislation is:

- **$68M to $92.3M** for fully-insured individual and small group market – both on and off Exchange.
- **$330M to $450M** for large employers in the self-insured market, including the State of Connecticut and its cities and towns.

The bill:

1. **Presumes a procedure, treatment, or drug is medically necessary, unless a carrier can prove otherwise under appeal.**

Without medical records, which reside in the possession of providers and members, carriers do not have the ability to rebut a presumption that a particular procedure, treatment, or drug is medically necessary. Without the ability to use prior authorization to determine medical necessity, carriers will not be able to:

- Promote the use of evidence-based care.
- Promote the safety and effectiveness of various treatments.
- Promote the appropriate use of drugs and services to avoid potentially dangerous side effects.
- Encourage that care be delivered in the most appropriate venue, at the appropriate time and frequency and by the most appropriate provider.
- Promote dialogue between the plan and clinician create tailored, patient focused treatment plans that promote adherence.

The number of treatments subject to prior authorization is relatively small -- less than 15% -- some plans report numbers in the single digits. That said, medical management is critically important, for instance, in combatting things like the ongoing opioid epidemic by identifying inappropriate prescribing patterns, under the guise of pain management, that contribute to the escalation of addiction.

While compromised quality is the dominant factor of concern, increases in the cost of care can't be ignored. The price tag of covering "any" treatment that's ordered by a provider **is almost incalculable.** The fiscal impact will be particularly acute for individuals, small employers, and others who purchase insurance on a fully-insured basis like those on the Exchange. While less than 30% of the overall market will be affected by this legislation, that same 30% is the most price sensitive and will be the least able to afford the associated cost.

Passage of the proposal will encourage more groups to go self-insured to get around the onerous requirements of the bill resulting in the opposite effect of what is intended.
State statute already provides for strict regulation of medical necessity determinations. Connecticut's law has served as a model for most of the country.

- CT was among the first states in the nation to implement an independent, third-party, external appeal mechanism for both consumers and providers. Matters in question are forwarded through the Department of Insurance to an outside entity made up of physicians within that particular specialty area. The Independent Review Organization (IRO) reviews all the relevant information from both sides and issues a decision that is binding on both parties.
- The Department of Insurance reports that external appeals generally split roughly 50/50, with half being decided in favor of the provider/member and half in favor of the health plan, suggesting that the process fairly arbitrates matters of legitimate dispute.

Consider that prior authorization contemplates:

- Opioids prescribed for patients also receiving benzodiazepines.
- Medications prescribed as "off-label" for indications not approved by FDA.
- Antipsychotic medications prescribed for children and adolescents.
- Promotion of high value care in Medicare Advantage and Part D plans.
- Best price and quality for durable medical equipment in Medicare FFS.
- Evidence-based guidelines for diagnostic imaging in Medicare FFS.

The value of medical management is widely recognized in numerous federal and state government-sponsored programs like Medicare and Medicaid.

2. Prohibits the use of step-therapy.

There is wide agreement on the need to control the skyrocketing rise in prescription drug prices. Carriers use step therapy as one tool to manage the cost of pharmacy to promote affordability of coverage.

By requiring members to try lower cost, quality indicated drugs, before accessing the higher cost equivalents, pharmaceutical manufacturers are incented to keep their prices low. That differential translates to lower overall premiums. **Without step therapy, manufacturers will be free to charge whatever they choose because coverage will be mandatory – the question will be whether consumers can still afford coverage.** Pharmacy

trend is increasing by over 20% annually accounting for an ever-increasing proportion of every health care dollar spent. Passage of this legislation will have the unintended result of more people going uninsured.

Step therapy also promotes best practice. In fact, the FDA sets forth the indications for many step therapy treatment regimens that are followed by health carriers; and furthermore,
Connecticut state statute already provides for considerable step therapy protections.

- Health insurers are barred from using step therapy for more than sixty days. After sixty days, a provider can render a regimen "clinically ineffective" and require that the carrier provide coverage for a different drug.
- State statute provides for an automatic "override" provision that can be accessed at any point in the process under certain conditions.
- The Insurance Department is authorized to fine or penalize any insurer who doesn't abide by the law.

3. Changes the definition of clinical peer.

The bill removes the term “similar” from the phrase “same [or similar] specialty.” The consequence of that small change is very significant. Passage of this provision will result in an end to the prior authorization process. Finding doctors in the exact same sub-specialty for every review undertaken within the tight time frames required by statute is almost impossible rendering the function unworkable.

Physicians specialize in many areas beyond their primary focus but, this legislation negates their ability to act as a clinical peer for purposes of authorizing care.

Please consider that:

- 65% of physicians reported that at least 15-30% of medical care is unnecessary. (PLOS One)
- Between $200-$800 billion is wasted annually on excessive testing and treatment. (Institute of Medicine)
- Many traditional Medicare beneficiaries receive “low value” care – where there is little or no clinical benefit or where risk outweighs potential benefit, at an estimated cost of $2.4-$6.5 billion a year. (MedPAC)
- Just 5 low-value services account for more than $25B in unnecessary spending. (Task Force on Low Value Care)
- Nearly half of hospitalized children and teens were given at least one drug combination that could have led to adverse outcomes – e.g., opioids, antibiotics, and other infection-fighting drugs. (Journal of Pediatrics)
- Up to half of all antibiotic use is inappropriate, exposing patients to additional risks. (JAMA)

If enacted, this legislation will represent the single most expensive mandate ever passed. We respectfully urge the committee’s opposition to S.B. 415.